Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

WILLIS KNIGHTON MED CENTER
PO BOX 32600
SHREVEPORT LA 71130

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-10-4237-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The adjuster Dian Thiele stated this will be approved as long as it pertains to the same eye, attached are the medical records the EOB and UB04."

Amount in Dispute: $7,421.50

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "There is no record of the requestor or the surgeon attempting to obtain preauthorization for this outpatient surgery."

Response Submitted by: Texas Mutual Insurance Company 6210 E Hwy 290 Austin TX 78723

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
November 2, 2009	Outpatient Hospital Services	$7, 421.50	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.600 sets out the procedures for preauthorization, concurrent review or voluntary certification of healthcare.
4. This request for medical fee dispute resolution was received by the Division on May 26, 2010.

5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - DENIED IN ACCORDANCE WITH 134.600 (P)(12) AS THE TREATMENT/SERVICE IS IN EXCESS OF THE DIVISION'S TREATMENT GUIDELINES AS OUTLINED IN THE DISABILITY MANAGEMENT RULES EFFECTIVE 5/1/07. PLEASE REFER TO THE DISABILITY MANAGEMENT RULES, CHAPTER 137 ON THE DIVISION'S WEBSITE.
   - CAC-197 PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT
   - 930 –PRE-AUTHORIZATION REQUIRED, REIMBURSEMENT DENIED.

Issues

1. Under what authority is a request for medical fee dispute resolution considered?
2. Was authorization obtained for services in dispute according to 28 Texas Administrative code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor provided services in the state of Louisiana on November 2, 2009 to an injured employee with an existing Texas Workers' Compensation claim. The requestor was not satisfied with the respondent's final action. The requestor filed for reconsideration and was denied payment after reconsideration. The requestor filed for dispute resolution under 28 Texas Administrative Code §133.307. The dispute is to be decided under the jurisdiction of the Texas Workers' Compensation Act and applicable rules.
2. 28 Texas Administrative Code §134.600 (P) states in part "Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; The division finds that preauthorization was required for the services in dispute.
3. No documentation was submitted to support that preauthorization was obtained , as required for the outpatient hospital service(s) in dispute in accordance with 28 Texas Administrative code §134.600. Therefore, reimbursement cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	January 26, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.